

may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

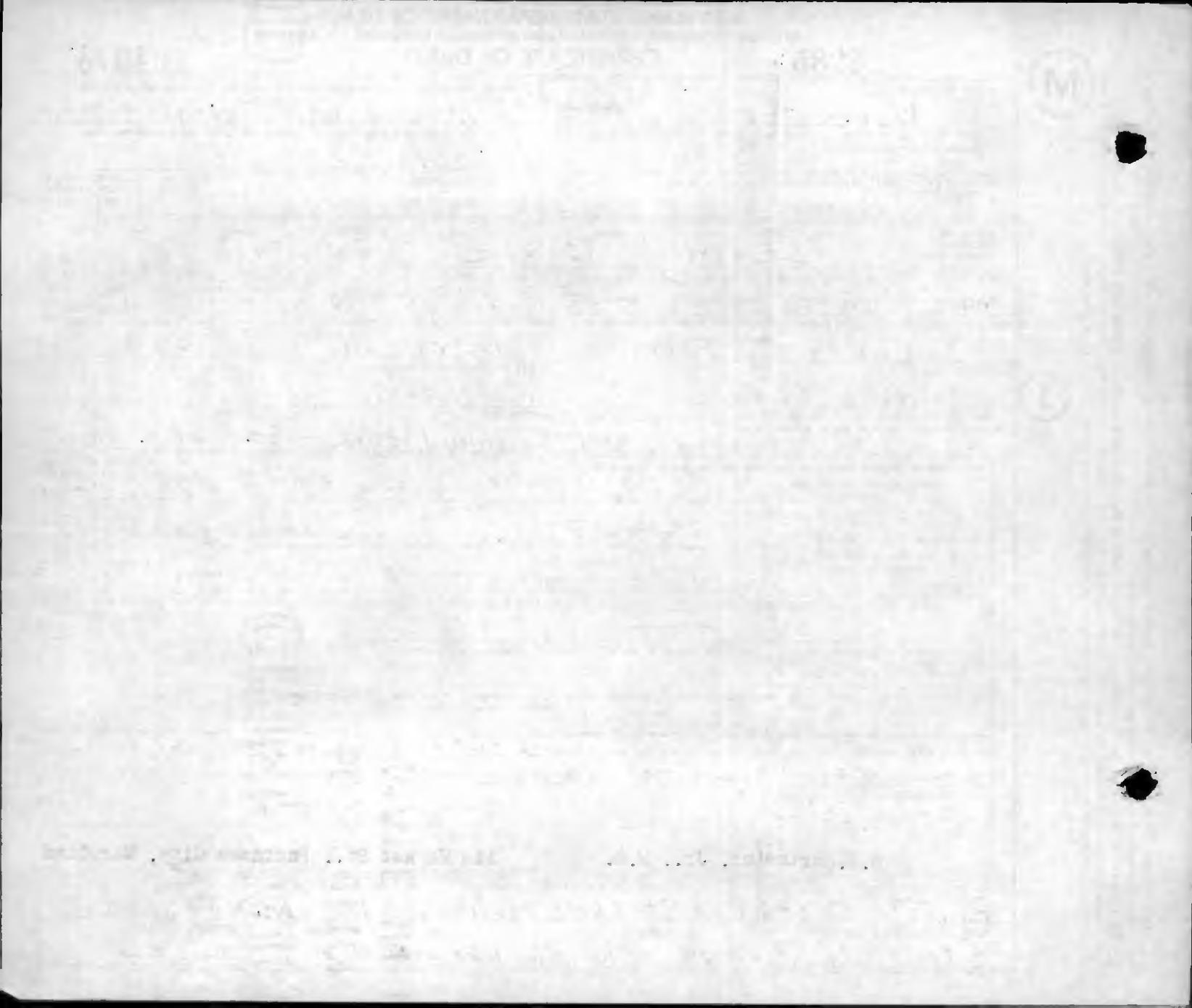
M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4985 04973

1. PLACE OF DEATH a. COUNTY <i>Worcester</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Worcester</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pocomoke</i>		c. LENGTH OF STAY IN 1b <i>Rural</i>		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pocomoke</i>		e. STREET ADDRESS <i>1 RT. 1</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>None</i>				d. STREET ADDRESS <i>1 RT. 1</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Levin</i>	Middle <i>Bayne</i>	Last	4. DATE OF DEATH <i>APRIL 29, 1961</i>	Month	Day	Year
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>March 8, 1880</i>	8. AGE (In years' last birthday) <i>81</i>	IF UNDER 1 YEAR Months <i>81</i>	IF UNDER 24 HRS. Days <i>81</i>	Hours <i>81</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Noah Bayne</i>		14. MOTHER'S MAIDEN NAME <i>Maria ?</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no; or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>220-10-8401</i>		17. INFORMANT <i>Emma Bayne - Pocomoke, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>443X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral thrombosis with R.H. Hemiplegia</i> DUE TO (c) <i>Hypertensive Cardiovascular Disease</i> Several years <i>Arteriosclerosis, generalized, severe</i> Many years							
INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>24 Oct 1954</i> to <i>28 April 1961</i> , that (I) (we) last saw the deceased alive on <i>28 April 1961</i> , and that death occurred at <i>9 P.M.</i> from the causes and on the date stated above.							
22a. SIGNATURE <i>N. E. Sarterius, Jr.</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <i>N. E. Sarterius, Jr., M.D.</i>		22d. ADDRESS <i>114 Market St., Pocomoke City, Maryland</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>5-3-61</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>St. Luke Holiness</i>		23d. LOCATION (City, town, or county) (State) <i>Pocomoke, Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar Wharton - New Church, Va.</i>		ADDRESS		25a. REC'D BY REGISTRAR <i>Arthur S. Kraus</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	
				DATE <i>MAY 4 '61</i>			



O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

O FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

O HOSPITAL OR ATTENDING PHYSICIAN: The law requires

VS A1S (4)
15M 10/52

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4986

CERTIFICATE OF DEATH

Reg. Dist. No.

04974

1. PLACE OF DEATH a. COUNTY Worcester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Pocomoke City		c. LENGTH OF STAY IN 1b 3 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Pocomoke City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D. 3		e. STREET ADDRESS R.F.D. 3		f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) BESSIE		First MAE	Middle BLADES	Last April	DATE OF DEATH Month	Day 21	Year 1961
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH April 5, 1910	9. AGE (In years last birthday) yrs. 51	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME John William Taylor				14. MOTHER'S MAIDEN NAME Lula Dunston			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---0		17. INFORMANT Howard F. Blades, Pocomoke City, Md.		Address R.F.D. 3	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertensive degeneration</i> DUE TO 422.2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). DUE TO 422.2 (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). DUE TO 422.2 (c)							
INTERVAL BETWEEN ONSET AND DEATH 3 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1959 , to 4-21-61 , that I last saw the deceased alive on 4-19-61 , and that death occurred at 1 A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) C. E. Critcher M.D. DATE SIGNED 4-21-61							
ACTUAL SIGNATURE C. E. Critcher		PHYSICIAN'S NAME (Type) C. E. CRITCHER					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-23-61		22c. NAME OF CEMETERY Goodwill Methodist		22d. LOCATION (City, town, or county) (State) Rural-Pocomoke City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Bluff H. Watson		ADDRESS Pocomoke City, Md.		24a. REC'D BY REGISTRAR APP 25 '61		24b. REGISTRAR'S SIGNATURE	

M
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B

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

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**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**

CERTIFICATE OF DEATH

4987 **04975**

PLACE OF DEATH

a. COUNTY

WORCESTER

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

BERLIN

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

BERLIN

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

MARYLAND

b. COUNTY

WORCESTER

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

BERLIN

d. STREET ADDRESS

BROAD ST

e. IS RESIDENCE ON A FARM?

YES NO

**3. NAME OF DECEASED
(Type or print)**

First

Middle

Last

4. DATE OF DEATH

Month
APRIL

Day
7 Year
1961

5. SEX

F

6. COLOR OR RACE

VV

7. MARRIED **NEVER MARRIED**

WIDOWED **DIVORCED**

B. DATE OF BIRTH

SEPT. 13, 1893

9. AGE (In years last birthday)

67 yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY

OWN HOME

11. BIRTHPLACE (State or foreign country)

BERLIN MD.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

WILLIAM R. PURNELL

14. MOTHER'S MAIDEN NAME

ANNIE MAC GREGOR

Address

MRS. J. S. GLBY PURNELL BERLIN MD.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Hepatocarcinoma

INTERVAL BETWEEN ONSET AND DEATH

6.72205

190.9

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19
p. m.

20d. INJURY OCCURRED
While Nat while
at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from **12/25/1960** to **April 7, 1961**, that (I) (we) lost sight of the deceased alive on **7 April 1961**, and that death occurred on **7 April 1961**, from the causes and on the date stated above.

22a. SIGNATURE

J. P. Thomas
P. Y. Inc 20025

M.D. ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

Ocean City, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

BURIAL 4/9/61

23c. NAME OF CEMETERY OR CREMATORIAL

BUCKINGHAM

23d. LOCATION (City, town, or county)

BERLIN MD.

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

Anne A. Burbage Berlin Md

ADDRESS

25a. REC'D BY REGISTRAR

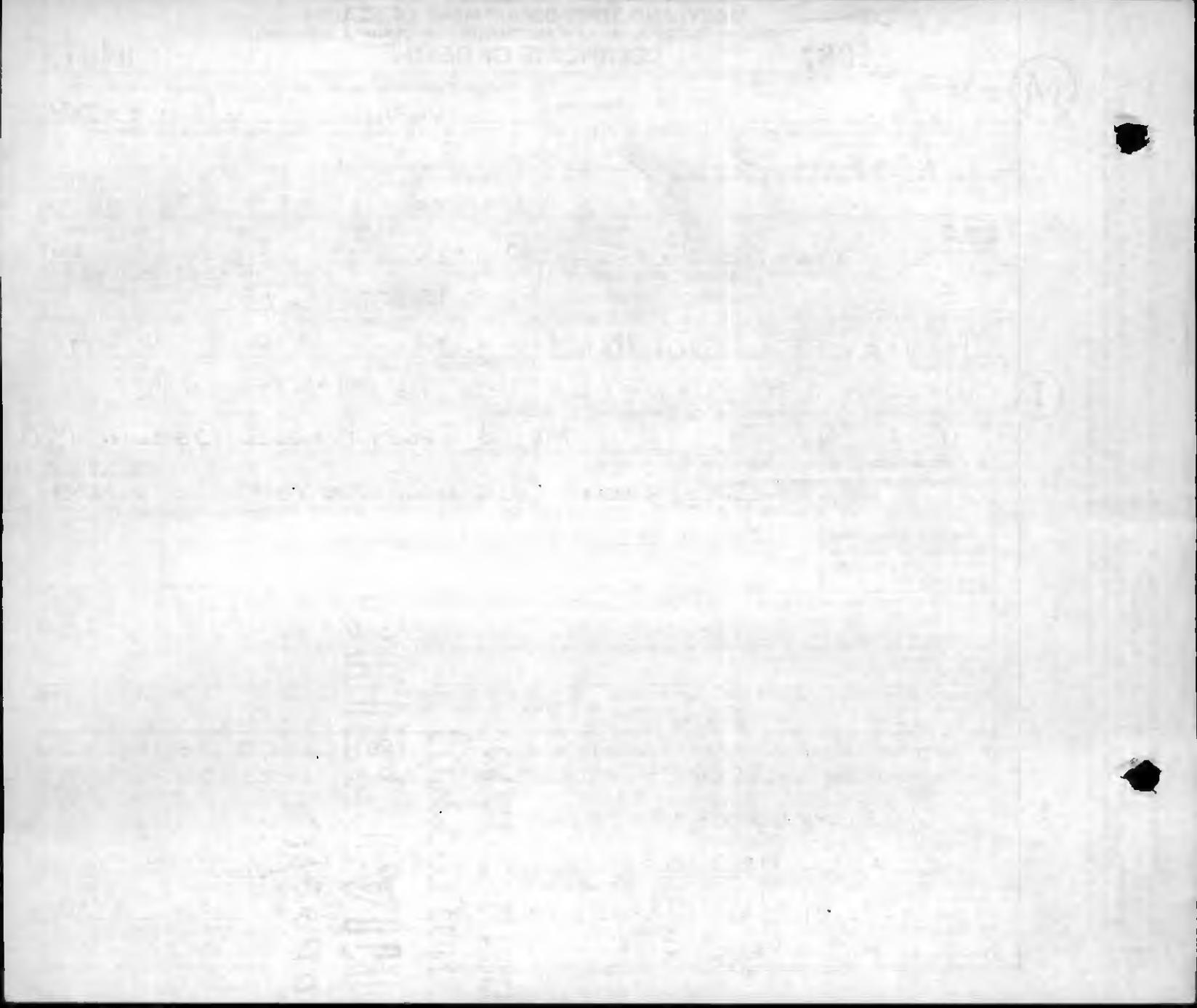
DATE

APR 11 '61

25b. REGISTRAR'S SIGNATURE

DATE

Arthur S. Kline



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1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

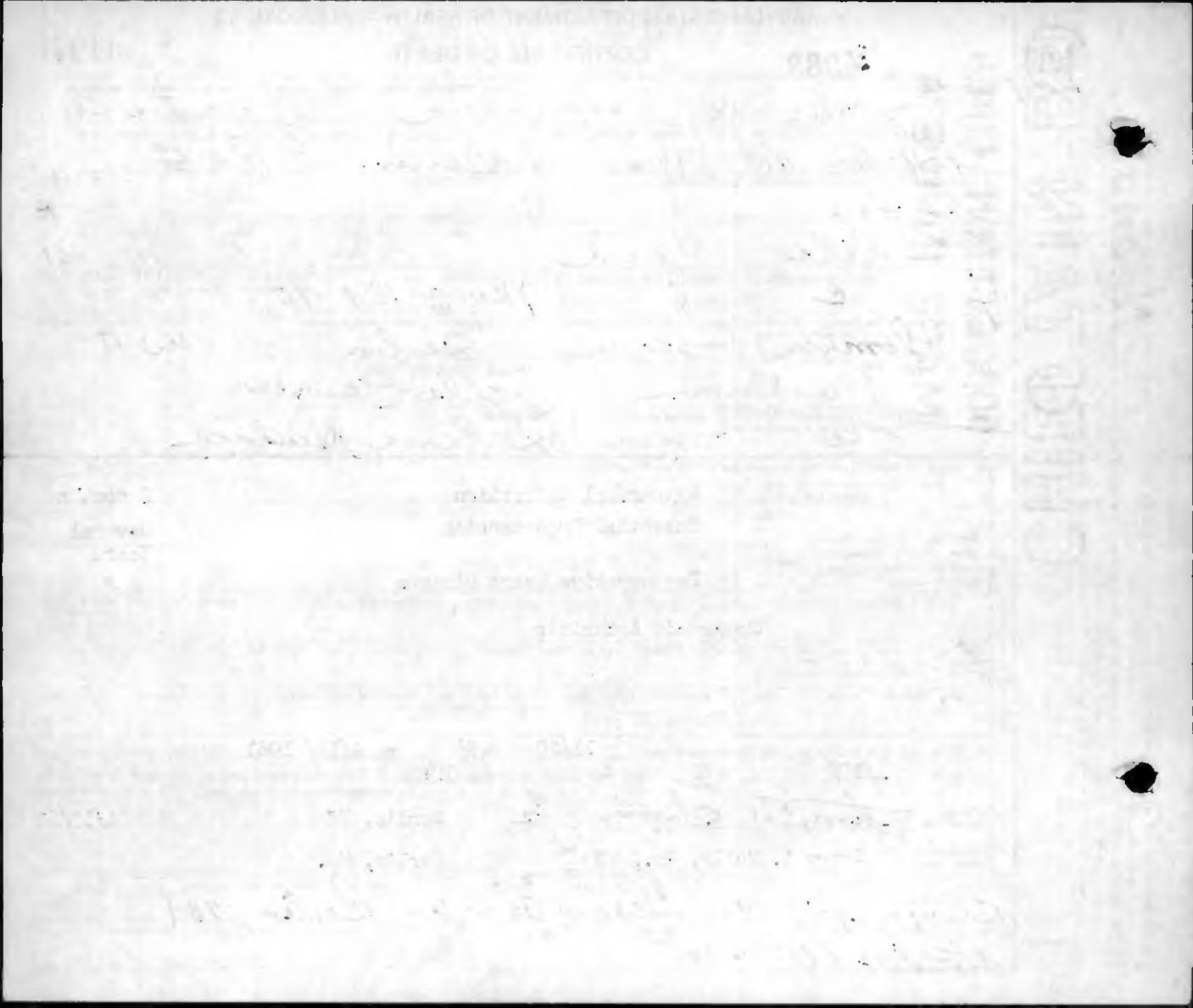
Item 9 Film G286 5/1/61 1wk

CERTIFICATE OF DEATH

Reg. Dist. No.

04976

4983			
1. PLACE OF DEATH a. COUNTY <i>Worcester Co</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Berlin Md.</i>		c. LENGTH OF STAY IN lb <i>7 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Berlin</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Berlin B-D-B</i>	
3. NAME OF DECEASED (Type or print) <i>Velma Coard</i>		First <i>Velma</i>	Middle <i>Coard</i>
4. DATE OF DEATH <i>4 11 1961</i>		Month <i>4</i>	Day Year <i>11 1961</i>
5. SEX <i>f</i>	6. COLOR OR RACE <i>c</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>May 2, 1871</i>
9. AGE (In years (or birthday) <i>89</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>	11. KIND OF BUSINESS OR INDUSTRY <i>None</i>	12. BIRTHPLACE (State or foreign country) <i>Berlin</i>
13. FATHER'S NAME <i>? unknown</i>	14. MOTHER'S MAIDEN NAME <i>Ella Sawyer</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> (If yes, give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO. <i>none</i>	INFORMANT <i>Selena Hudson</i>	17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>420.1</i> (b) DUE TO Essential Hypertension (c) DUE TO Degenerative Heart Disease	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Rheumatoid Arthritis</i>			18. INTERVAL BETWEEN ONSET AND DEATH <i>2 months</i> <i>Several Years</i> <i>8</i>
19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>11/20</i> , 19 <i>56</i> , to <i>p 4/10/ 1961</i> , that I last saw the deceased alive on <i>4/10/ 1961</i> , and that death occurred at <i>10:30 M</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Berlin, Md.</i>	
ACTUAL SIGNATURE <i>Ivory U. Sully Jr.</i>		DATE SIGNED <i>4/13/61</i>	
PHYSICIAN'S NAME (Type) <i>Ivory U. Sully, Jr., MD</i>		Berlin, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4-17-1961</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Bethel Town Cemetery</i>	22d. LOCATION (City, town, or county) <i>Berlin Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Beverly McWest</i>		ADDRESS	24a. REC'D BY REGISTRAR DATE <i>APR 25 '61</i>
			24b. REGISTRAR'S SIGNATURE <i>Charles S. Knobell</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **04977**

4989

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Ward			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City (Rural)		c. LENGTH OF STAY IN 1b d. STREET ADDRESS Route 2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Edward		First	Middle		
4. DATE OF DEATH Apr. 18 1961		La.	Month		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 19, 1902		
9. AGE (in years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Mill Work	11. BIRTHPLACE (State or foreign country) Maryland		
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Corbin			
14. MOTHER'S MAIDEN NAME Addie ?		15. WAS DECEASED EVER IN U. S. ARMED FORCES? No (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. Address		17. INFORMANT Bennie Schofield 631 1/2 Main St. Salisbury, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 916.0 DUE TO Conflagration INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO 					
DUE TO (c) 					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home	20f. (City or town) Worc	(County) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE N. E. Sartorius Sr		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4/19/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-23-61	22c. NAME OF CEMETERY OR CREMATORIAL Findly Chapel	22d. LOCATION (City, town, or county) Pocomoke, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Elgar Wharton Lecomae, Jr.		ADDRESS Edgar Wharton Lecomae, Jr.	24a. REC'D BY REGISTRAR Arthur S. Krause	24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Forward to the Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the registrar prior to burial or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

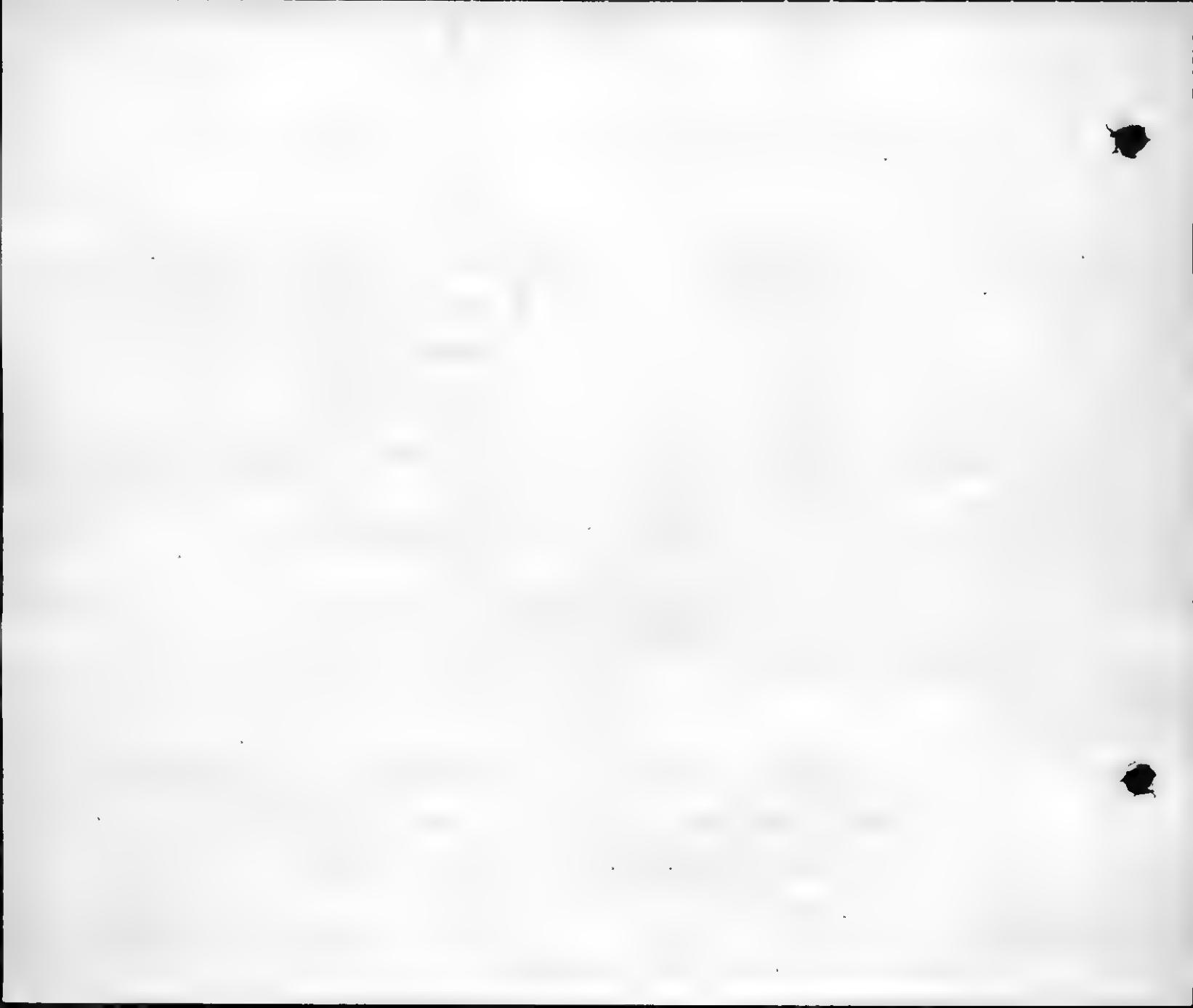
4990

CERTIFICATE OF DEATH

Reg. Dist. No.

14978

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Maryland				
WORCESTER				b. COUNTY		WORCESTER				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS				
BERLIN		2 years		BERLIN		Rt # 3				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
RT # 3										
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH	Month	Day	Year		
H. REACE				Ellis	4	-	19	1961		
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years lost birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS		
M		A A.		Sept 10 1899		61 yrs	Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?				
				Maryland		U.S.A.				
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Address						
William Ellis		Annie Ellis		Mrs. Elizabeth Baker, Salisbury and						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT		INTERVAL BETWEEN ONSET AND DEATH				
No		No		Mrs. Elizabeth Baker, Salisbury and		15 min				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		DUE TO								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary Thrombosis								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO								
		Hypertensive Cardiovascular Disease								
DUE TO		6 years								
(c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								
Chronic Alcoholism										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)	
19										
21. I certify that I attended the deceased from _____		8/17		to _____		4/10		, 1961		
alive on _____		1961		and that death occurred at		5:45 A.M.		from the causes and on the date stated above.		
ACTUAL SIGNATURE		Ivory U. Sully, Jr., MD		M.D.		Berlins, Md		ADDRESS (Street, city or town, state)		
PHYSICIAN'S NAME (Type)		Ivory U. Sully, Jr., MD				Berlins, Md		DATE SIGNED		
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)		(State)		
Burial		4-23-61		Ant. Calvary Cem.		Fruitland, Md.				
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE				
Thornton B. Jolley, Salisbury Md.				APR 28 '61		Charles E. Jones				
VS A15 (4) 15M 9/58										



1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4891

CERTIFICATE OF DEATH

04973

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Worcester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishop		c. LENGTH OF STAY IN 1b 50 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishop		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Thomas	Middle Henry	Lost	4. DATE OF DEATH April 30 1961	Month Month	Day Day	Year Year
5. SEX Male		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 8-25-1886	9. AGE (In years lost birthday) 74 yrs.	IF UNDER 1 YEAR: IF UNDER 24 HRS. Months 74	Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Garming		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Mary Lewis						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO no.		17. INFORMANT Bill. Lewis		Address Bishop, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 141.7		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH acute myocarditis				
		(b)						
		DUE TO Carcinoma of Tongue						
		(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 61 Court St.		20f. (City or town) (County) (State) Berlin		
21. I certify that I attended the deceased from Apr 23 1961 to Apr 30 1961 , that I last saw the deceased alive on Apr 23 1961 , and that death occurred at 334 P.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Elfford & Elizabeth Berlin Md.		
ACTUAL SIGNATURE CLIFFORD E. SCHOTTKY						DATE SIGNED BERLIN MD.		
PHYSICIAN'S NAME (Type) CLIFFORD E. SCHOTTKY								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 30, 1961		22c. NAME OF CEMETERY OR CREMATORIUM Hamblin		22d. LOCATION (City, town, or county) Whalegoelle Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Henry N. Watson		ADDRESS Poconoskoke City Md.		24a. REC'D BY REGISTRAR DATE MAY 4 '61		24b. REGISTRAR'S SIGNATURE Arthur & sons		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4992 CERTIFICATE OF DEATH

(14980)

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached from use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Maryland		b. COUNTY		Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
WEST OCEAN City		1 mos.		WEST OCEAN City		Rural							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural													
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year					
Charles A. MASSEY		A.		MASSEY	4	18	1961						
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years lost birthday) 85 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min			
Fm		AA		5-13-1875									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?							
Midwife		MATERNITY		Maryland		U.S.A.							
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME											
Charles E. Davis		Carolyn Smack											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		INFORMANT		Address							
				Mrs. Ida Purcell, Berlin, Md., Pt #3									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Degenerative Heart Disease													
443X DUE TO													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)													
Hypertensive Cardiovascular Disease DUE TO													
(c)													
" "													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
Senility													
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>													
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
						4/2 1954							
21. I certify that I attended the deceased from alive on		4/18 1961		to 4/18 1961		, that I last saw the deceased							
ACTUAL SIGNATURE		ADDRESS (Street, city or town, state)										DATE SIGNED	
Ivory U. Sully, Jr., MD		Berlin, Md.										4/20/61	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)		(State)					
Burial		4-22-61		EVERGREEN CEM-		BERLIN, Md.							
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE							
Thornton B. Jolley, Salisbury, Md.				APR 28 '61		Charles S. Thorne							



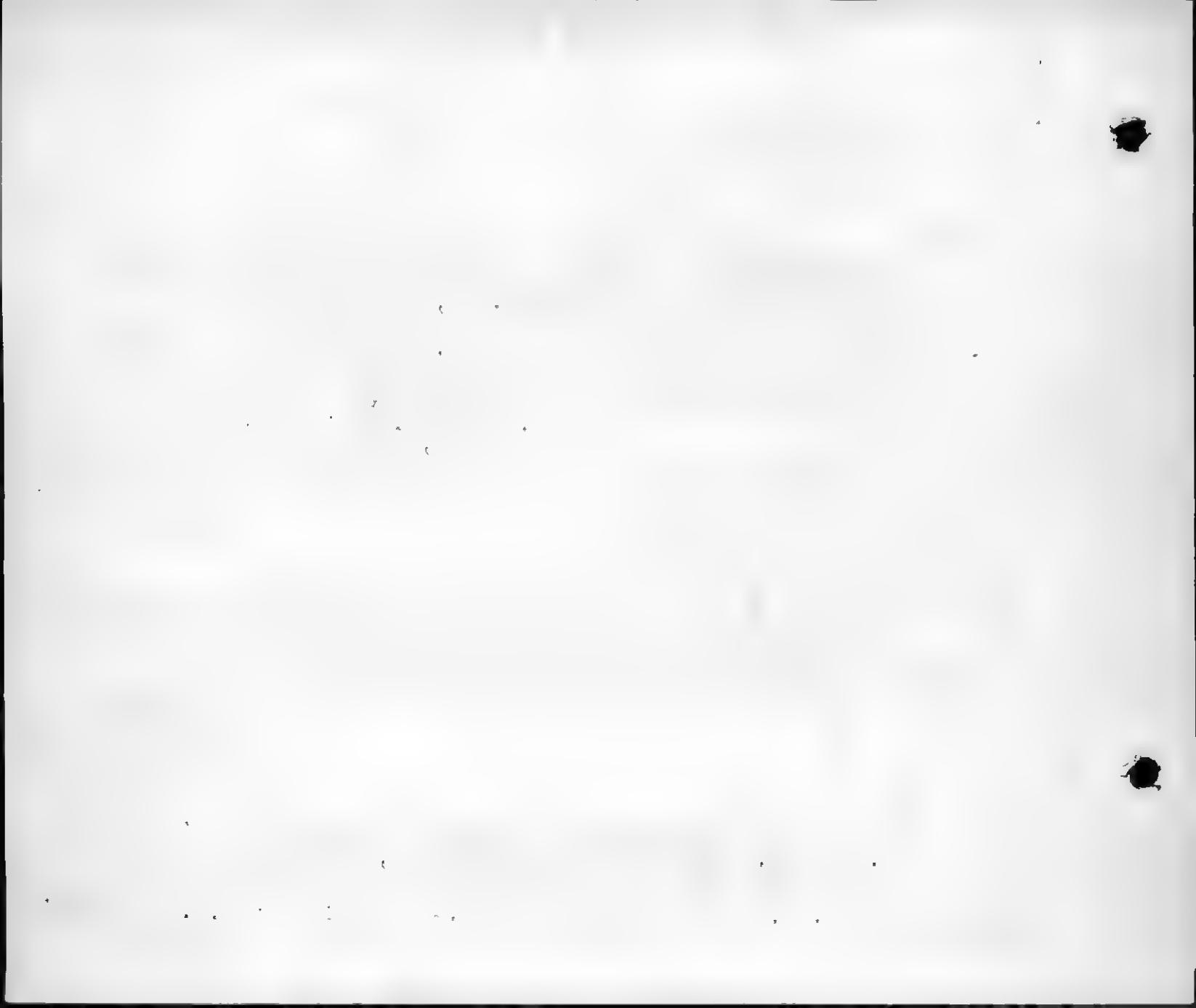
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be rehoned by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Worcester		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Willards	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Berlin Nursing Home		d. STREET ADDRESS Main St	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First CLEORA	Middle LEE	Last PHILLIPS
4. DATE OF DEATH	Month APRIL	Day 23rd	Year 19 61
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 20, 1876
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months 2 yrs	11. IF UNDER 24 HRS Hours 3 hrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Wico County-Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William Thomas Brumley		14. MOTHER'S MAIDEN NAME Jane Ennis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. Mrs. Vivian P. Ball (Grand-Daughter) Willards, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocardiitis		INTERVAL BETWEEN ONSET AND DEATH 2 yrs - 3 yrs	
DUE TO Hypertension			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) acute upper respiratory disease (common cold)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) N/A	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. N/A 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A	
20f. (City or town) N/A		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1958 to date of death , that (I) (we) last saw the deceased alive on 4-23 1961 , and that death occurred at 3 P.M. from the causes and on the date stated above.		22b. DATE SIGNED Apr. 24 /1961	
22a. SIGNATURE Frank Lewis		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Dr. Frank R. Lewis		22d. ADDRESS Willards, Maryland	
23a. BURIAL, CREMAT. ON REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 26. 1961	
23c. NAME OF CEMETERY OR CREMATORIAL Lime Church Cem. - Near Pittsville-R.D. #1		23d. LOCATION (City, town, or county) Md.	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY SALISBURY MARYLAND		25a. REC'D BY REGISTRAR DATE APR 26 '61	
		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

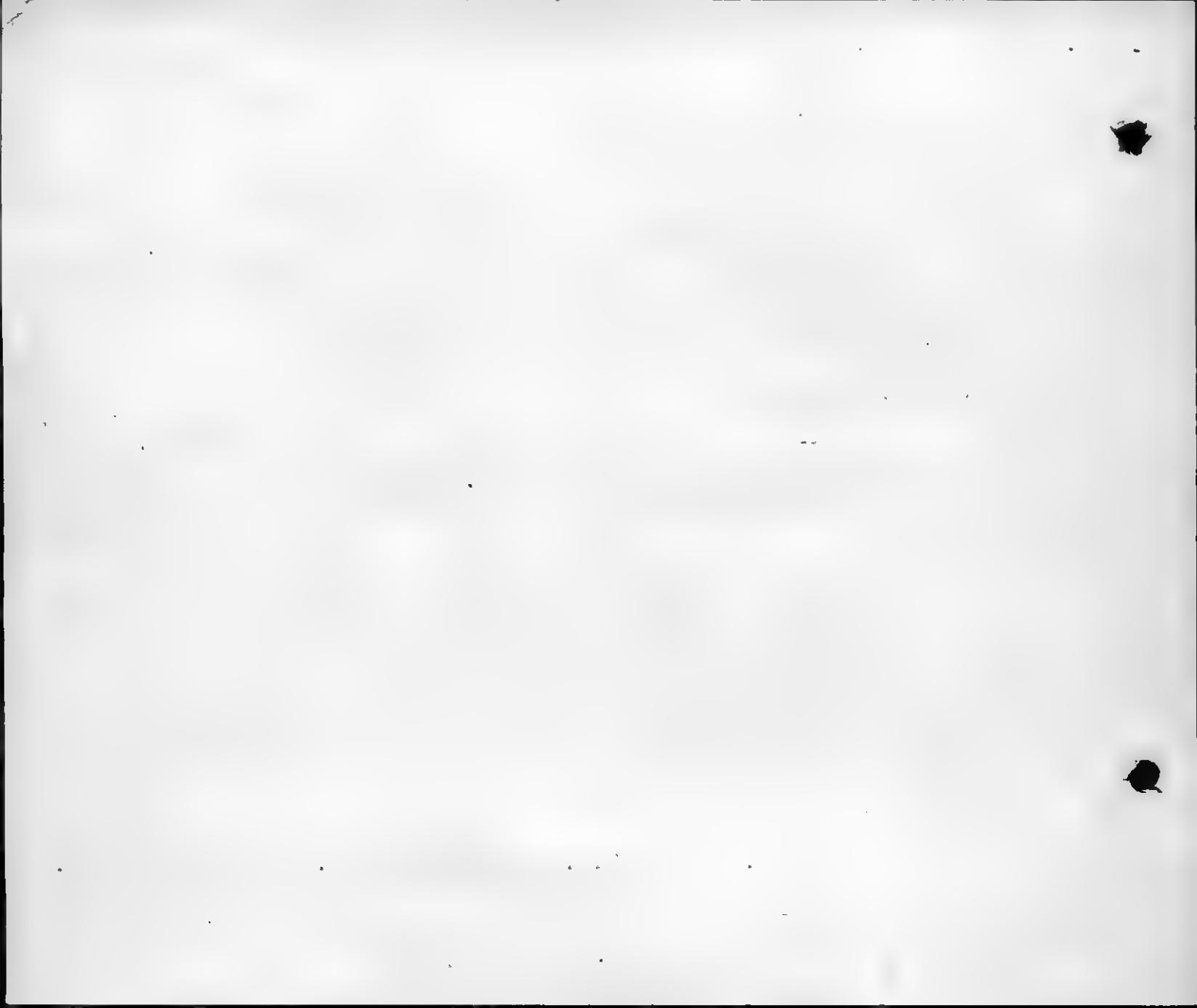
TO BURIAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

(14982)

1. PLACE OF DEATH a. COUNTY Worcester		2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City		b. COUNTY Worcester	
c. LENGTH OF STAY IN 1b 60 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 411 Market Street		d. STREET ADDRESS 411 Market Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First SADIE	Middle O.	Last POWELL
4. DATE OF DEATH	Month April	Day 27	Year 19 61
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 29, 1873
9. AGE (In years last birthday) 87 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Schoolteacher	11. KIND OF BUSINESS OR INDUSTRY Education	12. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Sewell D. Powell	14. MOTHER'S MAIDEN NAME Alice Ball		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. ---	17. INFORMANT Mrs Ruth Powell, Pocomoke City, Md.	Address 411 Market St.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 433-1		INTERVAL BETWEEN ONSET AND DEATH Minutes	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Pulmonary Oedema		DUE TO Ventricular Fibrillation	2 days
		DUE TO Pulmonary Oedema	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d)		DUE TO Degenerative Heart Disease	years 2 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Apr. 27, 1961 to Apr. 27, 1961 , that (I) (we) last saw the deceased alive on Apr. 27, 1961 , and that death occurred at 2:45 AM , from the causes and on the date stated above		22b. DATE SIGNED Apr. 28, 1961	
22a. SIGNATURE Charles W. Trader		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. ADDRESS 302 Market St., Pocomoke City, Md.
22c. PHYSICIAN'S NAME (Type) Charles W. Trader, M.D.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4-29-61	23c. NAME OF CEMETERY Presbyterian	23d. LOCATION (City, town, or county) (State) Pocomoke City, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Robert H. Watson		ADDRESS Pocomoke City, Md.	25a. REC'D BY REGISTRAR MAY 1 '61
			25b. REGISTRAR'S SIGNATURE Arthur S. Evans



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Worcester</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Worcester</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>	c. LENGTH OF STAY IN 1b <i>75 yrs</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>None</i>	d. STREET ADDRESS <i>Snow Hill</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type in ink) <i>George W. Burnell</i>		First <i>George</i>	Middle <i>R.</i>	Last <i>Burnell</i>	4. DATE OF DEATH <i>April 11 1961</i>	Month <i>April</i>	Day <i>11</i>	Year <i>1961</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 25-1885</i>	9. AGE (In years at birthday) <i>75 4/16</i>	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min		
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Taylor</i>		11. KIND OF BUSINESS OR INDUSTRY <i>Timber Mill</i>		12. BIRTHPLACE (State or foreign country) <i>Snow Hill MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>None</i>		
13. FATHER'S NAME <i>Wesley Burnell</i>		14. MOTHER'S MAIDEN NAME <i>Annie Morris</i>						
15. WAS DECEASED EVER IN S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>220-12-0033</i>		17. INFORMANT <i>Mrs. Rosaria Burnell</i>	Address <i>205 Pitt Street, Snow Hill, MD</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH <i>5 hours</i>		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White Nat white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from _____ 3-10, 1961, to _____ 4-11, 1961, that (I) (we) last saw the deceased alive on _____ 4-11-1961, and that death occurred at _____ M, from the causes and on the date stated above.								
22a. SIGNATURE <i>DAVID RAEFAT</i>		22b. DATE SIGNED <i>22b</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
22c. PHYSICIAN'S NAME (Type) <i>DAVID RAEFAT</i>		22d. ADDRESS <i>Snow Hill MD</i>						
23a. DUST AL CREMATION, 23b. DATE THEREOF REMOVAL (Specify) <i>Cremated April 14/61</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Holy Cemetery</i>		23d. LOCATION (City, town or county) <i>Snow Hill</i>		(State) <i>MD</i>		
24. FUNERAL DIRECTOR'S SIGNATURE <i>Velma E. Dennis</i>		ADDRESS <i>Snow Hill, MD</i>		25a. REC'D BY REGISTRAR DATE <i>MD 14 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Arline S. Thomas</i>		



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1996 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

114984

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate using the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. They should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Md. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles Williams Richardson		First	Middle
4. DATE OF DEATH April 7, 1961		Last	Month
5. SEX M		6. COLOR OR RACE W (White)	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH May 26, 1913		9. AGE (In years Since birth) 87 yrs.	10. IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tire Clerk		10b. KIND OF BUSINESS OR INDUSTRY Clerical	11. BIRTHPLACE (State or foreign country) Berlin Md.
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME John Richardson	
14. MOTHER'S MAIDEN NAME Sadie Williams		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	
16. SOCIAL SECURITY NO. 224-05-3518		17. INFORMANT MRS. E. W. RICHARDSON, EVERGREEN MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Suicide by carbon monoxide Interval between onset and death 7 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Carbon monoxide fumes from gas burner caused heart attack and death.	
20c. TIME OF INJURY Month, Day, Year Hour 4-6 p.m. 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1401 Berlin
20f. (City or town) Berlin		(County) (State) (Md.)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE N.E. Sartorius, Jr.		DATE SIGNED 4/6/61	
EXAMINER'S NAME (Type) N.E. Sartorius, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 4/8/61		22b. DATE THEREOF 4/8/61	
22c. NAME OF CEMETERY OR CREMATORIUM EVERGREEN		22d. LOCATION (City, town, or county) (State) Berlin MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Anna H. Burge Berlin Md.		24a. REC'D BY REGISTRAR DATE APR 10 '61	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

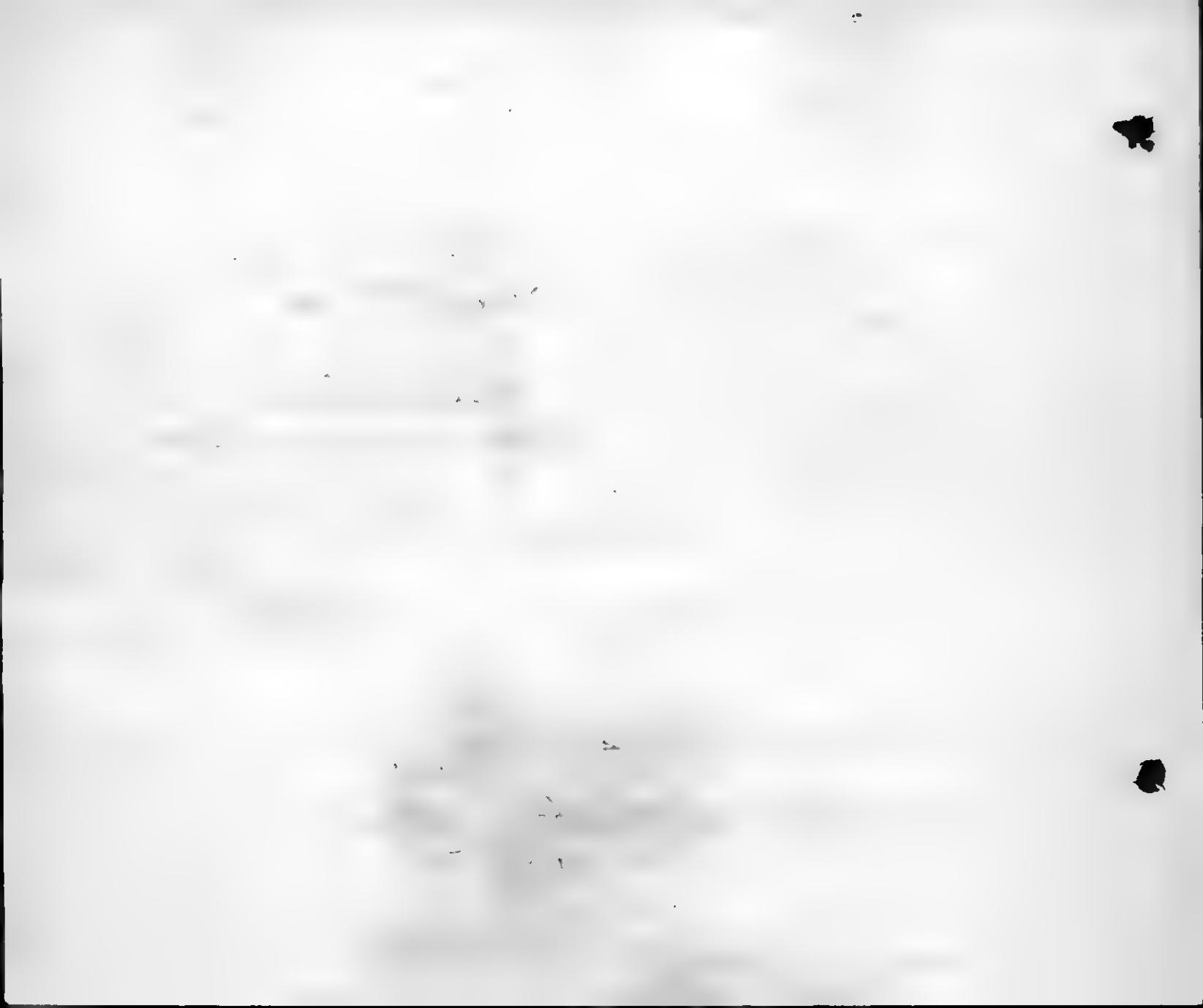
4997

CERTIFICATE OF DEATH

Reg. Dist. No.

04985

1. PLACE OF DEATH a. COUNTY WORCESTER		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIX (RURAL)		c. LENGTH OF STAY IN 1b 75 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DELLA.		First RICHARDSON	Middle Last
4. DATE OF DEATH APRIL 10 1961	Month Year	Day	Year
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 11, 1885
9. AGE (in years lost birthday) 75 yrs.	10. IF UNDER 1 YEAR Months No	11. IF UNDER 24 HRS. Months No	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) WHALEVILLE MD		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME WILLIAM JAMES JONES		14. MOTHER'S MAIDEN NAME ALEXINIA SARVIS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NO	
17. INFORMANT MR. THOMAS ZULLEN, BERLIN MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which give rise to immediate cause (a), stating the under- lying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 6 days	
DUE TO Essential hypertension		SEVERE YEARS	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from alive on 4/10 1961 , and that death occurred at 10:35 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Berlin Md	
ACTUAL SIGNATURE Ivory U. Sulley Jr. M.D.		DATE SIGNED 4/11/61	
PHYSICIAN'S NAME (Type) Ivory U. Sulley Jr. M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/13/61	
22c. NAME OF CEMETERY OR CREMATORIUM Twp. Berlin		22d. LOCATION (City, town, or county) BERLIN (R.F.D.) MD	
23. FUNERAL DIRECTOR'S SIGNATURE Anna A. Bell Jr.		24a. REC'D BY REGISTRAR DATE APR 13 '61	
ADDRESS 1212 2nd St.		24b. REGISTRAR'S SIGNATURE C. L. S. Kraus	



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. (1-301)

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Worcester		a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
Pocomoke (Rural) all life		Pocomoke City (Rural)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
Home		Route 2	
e. LENGTH OF STAY IN lb		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle
Ester			Schofield
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
Female	Negro		Feb. 6, 1885
9. AGE (in years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
76 yrs.	Domestic	Maryland	U.S.A.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Gus Bevins		Ellen ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
No		17. INFORMANT	
		Bernie Schofield 631½ Main St. Salisbury, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
716.c Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Carplagration } DUE TO (c)		Short	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
19		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home	
20f. (City or town) Worc.		(County) (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>N.E. Sartorius, Jr.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) N.E. Sartorius		DATE SIGNED 4/19/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-23-61	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Edgar Wharton - Pocomoke, Va.		22d. LOCATION (City, town, or county) (State) Pocomoke, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar Wharton - Pocomoke, Va.		24a. REC'D BY REGISTRAR DATE APR 24 '61	
		24b. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 24 hours after death. VR A15 (4) 15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 11 Film G285 4/17/61 mh

114907

1. PLACE OF DEATH
a. COUNTY

Worcester

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Showell

c. LENGTH OF STAY IN b.

5 Yrs

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

XXX

First

Middle

Last

Showell

e. STREET ADDRESS

f. IS RESIDENCE
ON A FARM?
YES NO

3. NAME OF
DECEASED
(Type or print)

ANNIE

ELIZABETH

STULLER

4. SEX

First

Middle

Last

5. SEX

Second

Third

XXX

Month

Day

Year

6. COLOR OR RACE

Female

White

4. DATE
OF
DEATH

April 9

1961

IF UNDER 24 HRS.
Hours _____ Min. _____

7. MARRIED NEVER MARRIED

b. DATE OF BIRTH

8. WIDOWED

Divorced

Feb. 28, 1873

9. AGE (in years) IF UNDER 1 YEAR
last birthday Months Days Hours Min.

88 yrs.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (County & State, or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Thomas Nelson

14. MOTHER'S MAIDEN NAME

Susan Alice Fleagle

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)

XX XX

XX

J. H. Stuller Showell, Md.

INTERVAL BETWEEN
ONSET AND DEATH

16. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY;
IMMEDIATE CAUSE (e)

444X
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

acute myocarditis
Hypertension
Senility

MEDICAL CERTIFICATION

17. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) 19. WAS AUTOPSY
PERFORMED?

YES NO

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. While at work
p.m. 19 Not While at work

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 3-15, 61 to 4-7, 61, that (I) (we) last
saw the deceased alive on 4-5, 61, and that death occurred at 7h.M. from the causes and on the date stated above.

22a. SIGNATURE

Difford E. Schott

ATTENDING
PHYS.

MED.
DIRECTOR STAFF
PHYS.

22b. DATE
SIGNED

22c. PHYSICIAN'S
NAME (Type)

Difford E. Schott

22d. ADDRESS

BERLIN, MD.

23a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial 4/12/61

23b. DATE THEREOF

Church of God

23c. NAME OF CEMETERY OR CREMATORIUM

23d. LOCATION (City, town or county)

(State)

Uniontown, Md.

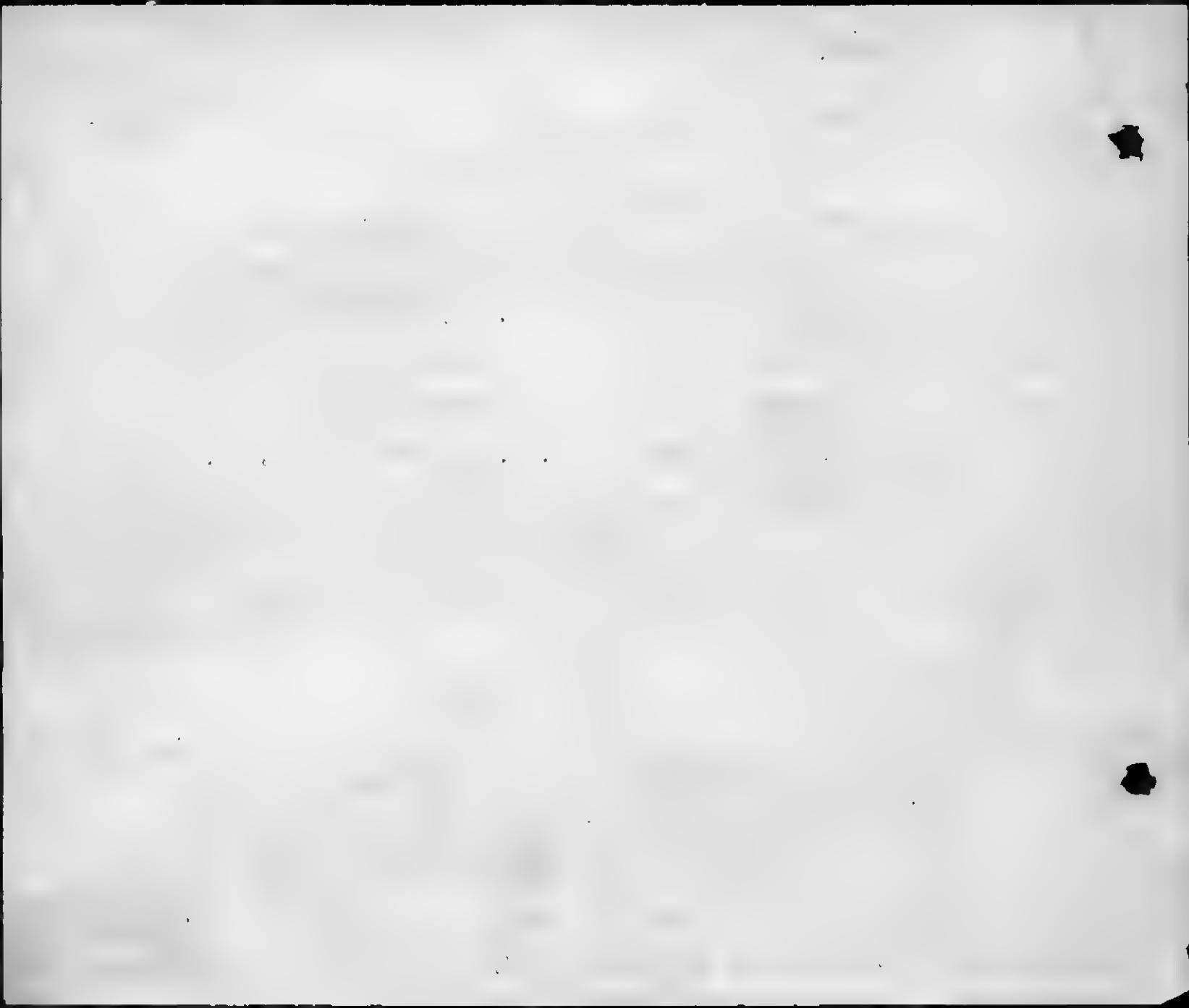
24. FUNERAL DIRECTOR'S SIGNATURE

Peter Whaley Selbyville, Del.

ADDRESS

25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

DATE APR 12 '61 Arthur S. Kraus



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

04968

1. PLACE OF DEATH a. COUNTY Worcester		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishop		c. LENGTH OF STAY IN 1b 10-yrs.		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Worcester		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishop	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION OR INSTITUTION		d. STREET ADDRESS Rt. #1 Box 46				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Mammie N. STURGIS		First Middle Last		4. DATE OF DEATH April 16th		Month Day Year 19 61					
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 1-18-95	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Isaac Turlington		14. MOTHER'S MAIDEN NAME Agnes Moore									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ND		16. SOCIAL SECURITY NO. ---		17. INFORMANT Fred Sturgis		Address Bishop, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 7 years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Berlin, Md.		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 4/19 , 19 54 , to 4/9 , 19 61 , that I last saw the deceased alive on 4/9 , 19 61 , and that death occurred at 2:15 AM , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Berlin, Md.		DATE SIGNED					
ACTUAL SIGNATURE <i>Ivory U. Sully, Jr.</i>											
PHYSICIAN'S NAME (Type) Ivory U. SULLY		Berlin, Md.				4-16-61					
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 4-16-61		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Calvary		22d. LOCATION (City, town, or county) Exmore, Va.					
23. FUNERAL DIRECTOR'S SIGNATURE Thomas Funeral Home		ADDRESS Accomac, Va.		24a. REC'D BY REGISTRAR DATE APR 19 '61		24b. REGISTRAR'S SIGNATURE Arthur J. Kline					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND												
CERTIFICATE OF DEATH												
1. PLACE OF DEATH a. COUNTY Worcester				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland				b. COUNTY Worcester				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Stockton				c. LENGTH OF STAY IN lb 4 months				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Stockton				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Holland's Nursing Home				d. STREET ADDRESS ---				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First SUSAN	Middle ANNE	Last TAYLOR	4. DATE OF DEATH April	Month 5	Day 19	Year 61				
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 26, 1867		9. AGE (In years last birthday) yrs. 93	IF UNDER 1 YEAR IF UNDER 24 HRS. Months ---		Days ---	Hours ---	Min. ---	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY ---				11. BIRTHPLACE (State or foreign country) Maryland				
13. FATHER'S NAME John Taylor				14. MOTHER'S MAIDEN NAME Sallie Elizabeth Jones				12. CITIZEN OF WHAT COUNTRY? USA				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None				17. INFORMANT Mrs J. Warren Smith, Stockton, Maryland				
Address												
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X												
DUE TO Central Thrombosis INTERVAL BETWEEN ONSET AND DEATH 2 days												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) Ateriosclerosis Generalized Yes												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)												
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> ---				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 4/2 1961 to 4/5 1961, that (I) (we) last saw the deceased alive on 4/5 1961 and that death occurred at 6PM , from the causes and on the date stated above.												
22a. SIGNATURE David Rafat				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 4/5/61				
22c. PHYSICIAN'S NAME (Type) DAVID RAFAT				22d. ADDRESS Sugar Hill, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 4-8-61				23c. NAME OF CEMETERY OR BURIAL Wesley Methodist				
23d. LOCATION (City, town, or county) Stockton, Maryland								(State)				
24. FUNERAL DIRECTOR'S SIGNATURE Robert H. Watson				ADDRESS Pocomoke City, Md.				25a. REC'D BY REGISTRAR DATE APR 10 '61				
								25b. REGISTRAR'S SIGNATURE Arthur S. Times				

